STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

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or more hours of service in a given day.

(6) Time for academic instruction when no treatment activity is going on cannot be included in the billing unit.

(7) Services shall be provided following a diagnostic assessment when authorized by the physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker or certified psychiatric nurse and in accordance with an ISP which must be fully completed within 30 days of initiation of the service.

12 VAC 30-60-70. Utilization control: Home health services.

I. Home Health Services.

1. Home health services that meet the standards prescribed for participation under Title XVIII, excluding any homebound standard, will be supplied.

2. Home health services shall be provided by a home health agency that is licensed by the Virginia Department of Health (VDH) [or that is certified by the VDH under provisions of Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act; OR that is accredited either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Community Health Accreditation Program (CHAP) established by the National League of Nursing]. Services shall be provided on a part-time or intermittent basis to a recipient in his place of residence. The place of residence shall not include a hospital or nursing facility. Home health services must be prescribed by a physician and be part of a written plan of care which the physician shall review, sign, and date at least every 60 days.

3. Covered Services: Any one of the following services may be offered as the sole home health service and shall not be contingent upon the provision of another service.

a. Nursing services,

b. Home health aide services,

c. Physical therapy services,

d. Occupational therapy services, or

e. Speech-language pathology services.

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(2) Occupational therapy services shall be directly and specifically related to an active written plan of care designed by a physician after any needed consultation with an occupational therapist registered and licensed by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and licensed by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine, or an occupational therapy assistant who is certified by the National Board for Certification in Occupational Therapy under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant, such services shall be provided under the supervision of a qualified occupational therapist, as defined above, who makes an onsite supervisory visit at least once every 30 days. This supervisory visit shall not be reimbursable.

(3) Speech-language pathology services shall be directly and specifically related to an active written plan of care designed and personally signed and dated by a physician after any needed consultation with a speech-language pathologist licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech Pathology. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech Pathology.

d. A visit shall be defined as the duration of time that a nurse, home health aide, or rehabilitation therapist is with a client to provide services prescribed by a physician and that are covered home health services. Visits shall not be defined in measurements or increments of time.

J. Durable Medical Equipment (DME) and Supplies.

a. DME provider shall retain copies of the CMN and all applicable supporting documentation on file for post payment audit reviews. Durable medical equipment and supplies that are not ordered on the CMN for which reimbursement has been made by Medicaid will be retracted. Supporting documentation is allowed to justify the medical need for durable medical equipment and supplies. Supporting documentation does not replace the requirement for a properly completed CMN. The dates of the supporting documentation must coincide with the dates of service on the CMN and the medical practitioner providing the supporting documentation must be identified by name and title.

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METHODS OF PROVIDING TRANSPORTATION

12 VAC 30-50-530.

DMAS will ensure necessary transportation for recipients to and from providers of covered medical services. DMAS shall cover transportation to covered medical services under the following circumstances:

A. Emergency air and ground ambulance transportation shall be covered as a medical service under applicable federal Medicaid regulations.

B. All other modes of transportation shall be covered as administrative expenses under 42 CFR § 431.53 and any other applicable federal Medicaid regulations. These modes include, but shall not limited to, non-emergency air travel, non-emergency ground ambulance, stretcher vans, wheelchair vans, common user bus (intra-city and inter-city), volunteer/registered drivers, and taxicabs. DMAS may contract directly with providers of transportation and/or with brokers of transportation services. DMAS may require that brokers not have a financial interest in transportation providers with whom they contract.

C. Medicaid provided transportation shall only be available when recipients have no other means of transportation available.

D. Recipients shall be furnished transportation services which are the most economical to adequately meet the recipients' medical needs.

E. Ambulances, wheelchair vans, taxicabs, and other modes of transportation must be licensed to provide services in the Commonwealth by the appropriate state and/or local licensing agency. Volunteer/registered drivers must be licensed to operate a motor vehicle in the Commonwealth and must maintain automobile insurance.

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COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

12 VAC 30-20-80. Coordination of Title XIX with Part A and Part B of Title XVIII.

The following method is used to provide benefits under Part A and Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:

1. ☒ All individuals eligible under the State's approved title XIX plan except Qualified Disabled Working Individuals.

2. ☒ Qualified Medicare beneficiaries provided by §301 of P.L. 100-360 as amended by § 8434 of P.L. 100-647.

3. ☒ Specified low-income Medicare beneficiary (SLMB) provided by § 1905(p) of the Act.

4. ☒ Qualifying Individuals-1: The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in §1902(a)(10)(E)(iv)(I) and subject to §1933 of the Act.

B. Part A group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups: Qualified Disabled & Working Individuals provided by §6408 of OBRA 1989 and Qualified Medicare beneficiaries provided by §301 of P.L. 100-360 as amended by §8434 of P.L. 100-647.

C. Payment of Part A and Part B deductible and coinsurance cost. Such payments are made in behalf of the following groups:

1. All individuals eligible for Title XVIII covered services.

2. Qualified Medicare beneficiaries provided by §301 of P.L. 100-360 as amended by §8434 of P.L. 100-647.

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12 VAC 30-20-150

A. The following charges are imposed on the categorically needy and Qualified Medicare Beneficiaries for services other than those provided under 42 CFR §447.53.

Service *	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay	
Inpatient Hospital	$100.00	-0-	-0-	State's average daily payment of $594 is used as basis.
Outpatient Hospital Clinic	-0-	-0-	$3.00	State's average payment of $136 is used as basis.
Clinic Visit	-0-	-0-	$1.00	State's average payment of $29 is used as basis.
Physician Office Visit	-0-	-0-	$1.00	State's average payment of $23 is used as basis.
Eye Examination	-0-	-0-	$1.00	State's payment of $30 is used as basis.
Prescriptions:				State's average per generic script of $25 is used as payment basis. State's average per brand name script of $97 is used as payment basis.
Generic	-0-	-0-	$1.00	
Brand Name	-0-	-0-	$3.00	
Home Health Visit	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Other Physician Service	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Rehab Therapy Services (PT, OT, Sp/Lang.)	-0-	-0-	$3.00	State's average payment $78 is used as basis.

*NOTE: The applicability of copays to emergency services is discussed further in this Attachment.

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B. The method used to collect cost sharing charges for categorically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers may accept the recipient's assertion that he is unable to pay the required copayment.

Recipients have been notified that inability to meet a copayment at a particular time does not relieve them of that responsibility.

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D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

The application and exclusion of cost sharing is administered through the program's MMIS. Documentation of the certified computer system delineates, for each type of provider invoice used, protected eligible groups, protected services and applicable eligible groups and services.

Providers have been informed about: copay exclusions; applicable services and amounts; prohibition of service denial if recipient is unable to meet cost-sharing changes.

E. Cumulative maximums on charges:

☒ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

F. Emergency Services. No recipient copayment shall be collected for the following services:

1. Services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

   a. Placing the patient's health in serious jeopardy;

   b. Serious impairment to bodily functions; or

   c. Serious dysfunction of any bodily organ or part; and

2. All services delivered in emergency rooms.

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12 VAC 30-20-160

A. The following charges are imposed on the medically needy and Qualified Medicare Beneficiaries for services other than those provided under 42 CFR §447.53.

Service *	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay	
Inpatient Hospital	$100.00	-0-	-0-	State's average daily payment of $594 is used as basis.
Outpatient Hospital Clinic	-0-	-0-	$3.00	State's average payment of $136 is used as basis.
Clinic Visit	-0-	-0-	$1.00	State's average payment of $29 is used as basis.
Physician Office Visit	-0-	-0-	$1.00	State's average payment of $23 is used as basis.
Eye Examination	-0-	-0-	$1.00	State's payment of $30 is used as basis.
Prescriptions Generic Brand Name	-0- -0-	-0- -0-	$1.00 $3.00	State's average per script of $25 is used as payment basis. State's average per brand name script of $97 is used as payment basis.
Home Health Visit	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Other Physician Service	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Rehab Therapy Services (PT, OT, Sp/Lang.)	-0-	-0-	$3.00	State's average payment $78 is used as basis.

*NOTE: The applicability of copays to emergency services is discussed further in this Attachment.

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B. The method used to collect cost sharing charges for medically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers may accept the recipient's assertion that he is unable to pay the required copayment.

Recipients have been notified that inability to meet a copayment at a particular time does not relieve them of that responsibility.

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D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

The application and exclusion of cost sharing is administered through the program's MMIS. Documentation of the certified computer system delineates, for each type of provider invoice used, protected eligible groups, protected services and applicable eligible groups and services.

Providers have been informed about: copay exclusions; applicable services and amounts; prohibition of service denial if recipient is unable to meet cost-sharing changes.

E. Cumulative maximums on charges:

☒ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

F. Emergency Services. No recipient copayment shall be collected for the following services:

1. Services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

   a. Placing the patient's health in serious jeopardy;

   b. Serious impairment to bodily functions; or

   c. Serious dysfunction of any bodily organ or part; and

2. All services delivered in emergency rooms.